MAP-130

PRIOR AUTHORIZATION FAX-FORM
Kentucky Medicaid Home Health Care Services Program
FAX NUMBER: 1-800-664-5749 CALL IN: 1-800-664-5725
DATE FORM COMPLETED____/____/_____

TYPE OR PRINT CLEARLY IN DARK INK ONLY. COMPLETE ALL QUESTIONS. CLEAN FORM REQUIRED FOR EACH SUBMISSION. ILLEGIBLE AND INCOMPLETE FORMS WILL BE UNPROCESSED.

SUPPLY ONLY_____ NEW PATIENT_____RE-AUTHORIZATION_____MODIFICATION_____UN-REVIEWED_____

Start Date on Plan of Care: ____/____/_____ Date CMS 485 completed: ____/___/_____

PATIENT: NAME: _____ _____
Last First MI **KY HEALTH CHOICES ID #**

ADDRESS: _____
Street City/State zip county

TELEPHONE: _____ **Height/Weight**_____ **DATE of BIRTH:** ____/___/_____

GENDER: M____ F____ IF UNDER AGE 21, EPSDT SPECIAL SERVICES RECEIVED? _____Y _____N

_____
Responsible party (if applicable) Name Address Relationship

IS PATIENT HOMEBOUND DUE TO MEDICAL CONDITION: _____Y _____N If no, explain justification for

HH services in lieu of outpatient services _____

_____

IS THERE A WILLING AND RELIABLE CAREGIVER _____Y _____N if no, please explain _____

_____

DATE RECIPIENT LAST SEEN BY THE PRIMARY PHYSICIAN _____/_____/_____

PRIMARY Dx(s) _____ **SECONDARY Dx(s)** _____
ICD-9-CM code and description ICD-9-CM code and description

_____

_____

HAS RECIPIENT BEEN DISCHARGED? _____Y _____N DATE OF DISCHARGE ____/____/_____

DISCHARGE REASON _____

IS RECIPIENT A RESIDENT OF A PERSONAL CARE HOME (PCH)? _____Y _____N

IF YES, NAME AND ADDRESS OF THE PCH _____

PRIMARY PHYSICIAN INFORMATION: NAME: _____

ADDRESS_____

PHYSICIAN'S UPIN_____ **PHYSICIAN'S TELEPHONE #** _____

PHYSICIAN ORDER FOR ALL REQUESTED SERVICES AND/OR SUPPLIES? _____Y _____N

AGENCY INFORMATION: NAME _____ **(Branch)** _____

ADDRESS _____

REQUESTOR'S NAME_____ **CONTACT (if different)** _____

TELEPHONE # _____ **FAX #** _____ **PROVIDER #** _____

RECIPIENT NAME: ____ **KYHEALTH CHOICES ID #:** ______________________

HH Care Services

Revenue Code	Type of Service, Frequency and Expected Duration	# Visits Requested	Start Date	End Date
_______	____	__________	______	____
_______	____	__________	______	____
_______	____	__________	______	____
_______	____	__________	______	____

WOUND: DESCRIPTION ____LOCATION___________________________
LENGTH _______ DEPTH ______WIDTH _____ CIRCUMFERENCE______ DECUBITIS _____Y ____N STAGE__________

WOUND: DESCRIPTION ____LOCATION___________________________
LENGTH _______ DEPTH ______WIDTH _____ CIRCUMFERENCE______ DECUBITIS _____Y ____N STAGE__________

WOUND: DESCRIPTION ____LOCATION___________________________
LENGTH _______ DEPTH ______WIDTH _____ CIRCUMFERENCE______ DECUBITIS _____Y ____N STAGE__________

PHYSICIAN'S WOUND TX ORDERS: ____

CLINICAL SUPPORTING DOCUMENTATION FOR GLOVES USED IN HH CARE:

CLINICAL SUPPORTING DOCUMENTATION FOR NUTRITIONAL SUPPLEMENTS:

CLINICAL SUPPORTING DOCUMENTATION FOR INCONTINENT SUPPLIES:

OTHER CLINICAL SUPPORTING DOCUMENTATION:

HH Care Disposable Medical Supplies-Revenue Code 270 and 279 Nutritional Supplements.

EXCLUDE ALL ADMINISTRATIVE SUPPLIES

Revenue Code	HCPCS Code	Item Description	Quantity/ Units	Start Date	End Date